Patient Enrollment Form

Last Name _____ First _____ MI_____

Home Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer_____

List covered dependants:

Name	Birth Date	Relationship

Quality Dental Plan – Total Amount Due _____

Payment Method:

- ☐ Cash
- ☐ Check
- ☐ Credit Card # _____ Exp date _____

Card Type: MasterCard/Visa/Discover

Signature _____

Please read and sign below:

Quality Dental Plan offers significant discounts on dental services. I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:

Fees for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. If you choose not to pay at the time of service you will be billed our usual and customary fees for such services.

Signature _____ Date _____